DOCUMENT RESUME

ED 288 885 TM 870 578

AUTHOR Glickman, Henry S.; And Others
TITLE Behavioral Analytic Approach to Placement of Patients in Community Settings.
PUB DATE Aug 86
NOTE 15p.; Paper presented at the Annual Meeting of the American Psychological Association (Washington, DC, August 22-26, 1986).
PUB TYPE Speeches/Conference Papers (150) -- Reports - Research/Technical (143)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Adjustment (to Environment); *Behavior Rating Scales; Behavior Standards; *Community Programs; *Daily Living Skills; *Deinstitutionalization (of Disabled); Evaluation Criteria; Group Homes; Institutionalized Persons; Interpersonal Competence; Interrater Reliability; Middle Aged Adults; Older Adults; Rehabilitation Programs; Residential Institutions; *Schizophrenia; *Social Adjustment; Test Validity
IDENTIFIERS *Current Behavior Inventory

ABSTRACT

Twenty adult psychiatric outpatients were assessed by their primary therapists on the Current Behavior Inventory prior to placing them in community settings. The diagnoses included schizophrenia, major affective disorder, dysthymic disorder, and atypical paranoid disorder. The inventory assessed behaviors in four areas: independent community living, interpersonal behavior, work or training activities, and symptom management. Ninety-five items were identified as scorable: (1) by a clinician as present or absent in a patients' current behavior; and (2) by a community setting administrator or "gatekeeper" as required or not required for admission to the community setting. Reliability of patient profiles was estimated by calculating the percentage of agreement between the therapist's and a second clinician's rating; the average percentage of agreement was 84.7%. The validity of the setting profile was estimated by comparing the behaviors rated by the gatekeepers as necessary for admission with the current behaviors observed in a sample of patients living in the setting; the average level of behavioral compliance with setting standards was 84.8%. Also included are a description of program planning at Harlem Valley Psychiatric Center, including their "triage" procedures on potential transfer patients; a list of essential behaviors; and lists of four groups requiring additional training in specific areas of social skills. (JGL)

****
* Reproductions supplied by EDRS are the best that can be made *
* from the original document. *
****

ED288885

BEHAVIORAL ANALYTIC APPROACH TO PLACEMENT OF PATIENTS IN COMMUNITY SETTINGS

Henry S. Glickman, Ph.D.
Paul Margolies, Ph.D.
Sandra S. Lash, MSW
Girish V. Shah, MD
Barbara Donaldson, M.A.
James Lewandowski, MSW

HARLEM VALLEY PSYCHIATRIC CENTER
WINGDALE, NEW YORK

Presented at the American Psychological Association Annual Meeting

August, 1986, Washington, D.C.

TM 870 578

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Henry Glickman

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

BEST COPY AVAILABLE

BEHAVIORAL ANALYTIC APPROACH TO PLACEMENT OF PATIENTS IN COMMUNITY SETTINGS

Henry S. Glickman, Ph.D.
Paul Margolies, Ph.D.
Sandra S. Lash, MSW
Girish V. Shah, MD
Barbara Donaldson, M.A.
James Lewandowski, MSW

Harlem Valley Psychiatric Center

Wingdale, New York

ABSTRACT

The Current Behavior Inventory was designed to facilitate an assessment and treatment planning process, that reflects the specific strengths and weaknesses of each patient, and the specific environmental requirements of each environmental setting. Ninety-five behaviors were identified after extensive consultation with clinicians at a state psychiatric facility. These were rated by clinicians familiar with each patient as currently performed or not. Administrators of a residence for adult psychiatric patients were also asked to rate the same behaviors, indicating in each case whether they were necessary or not for admission.

Reliability for the clinicians' ratings was quite high. Validity of the ratings by the setting administrators was measured by finding the degree of compliance with the setting requirements among the sample of 20 residents. This was also quite high. The data suggested the need for some refinements in instructions to raters and selection of items.

This behavior-analytic approach, emphasizing patient-situation interactions, may help to make clinical programs more precise and relevant.

BEHAVIORAL ANALYTIC APPROACH TO PLACEMENT OF PATIENTS IN COMMUNITY SETTINGS

Henry S. Glickman, Ph.D.
Paul Margolies, Ph.D.
Sandra S. Lash, MSW
Girish V. Shah, M.D.
Barbara Donaldson, M.A.
James Lewandowski, MSW

Harlem Valley Psychiatric Center
Wingdale, New York

Subject Index Terms: 2.8.2 Clinical/psychopathology/schiz.
2.2 Clinical/assessment

STATEMENT OF PROBLEM

Increasing attention has been paid in recent years to the instrumental and social difficulties associated with schizophrenia. Indeed, premorbid levels of functioning are often better predictors of outcome than psychotic symptoms (Strauss and Carpenter, 1974), and similar findings have been obtained when assessments are made at the point of discharge from a hospital (Growe, Klass, Rudolf, and Strizich, 1977). The efficacy of skills training programs in improving functioning has been amply documented (Wallace, Nelson, Liberman, Aitchison, Lukoff, Elder, and Ferris, 1980), although there have been problems in achieving generalization of these skills in the natural environment (Brown, 1982).

One response to this difficulty has been to conduct programs in the settings where the behaviors need to be performed. This has proved to be an effective approach when the conditions for in vivo training have been established (Fairweather, Sanders, Maynard, and Aessler, 1969, Stein and Test, 1978). Another approach is to put primary emphasis on the selection and definition of target behaviors,

in order to ensure that they meet the requirements of each setting in which a patient has to function. This focus on patient-situation interactions, rather than on skills defined independently, is consistent with the Behavior-Analytic Model of Goldfried and D'Zurilla (1969). Goldsmith and McFall (1975) used this model to identify problem situations and acceptable responses in a social skill training program for psychiatric inpatients.

The point of departure in the present study is different in two respects. Because the major concern is with successful adjustment in the community, a very large number of critical behaviors in different areas of functioning have to be considered. In addition, the settings where these behaviors are performed do not have to be estimated by judges: They are the specific residences, workshops, social clubs and treatment programs to which patients must adjust if they are to succeed in the community. It also follows that the standards of performance required by those settings is best determined not by a consensus of raters but by the people who control admission into them. Adjustment is thus defined as a match between the performance of a particular patient and the requirements of a particular setting.

This approach should improve the selection of patients for community programs, by basing it on valid environmental standards with real consequences. It should also make rehabilitation programs more precise, since they can be focused on the most relevant areas of behavioral change. Other functional evaluation instruments such as the NOSIE (Honigfeld, Gillis, Klett, 1966) or the PAMIE (Gurel, Linn, and Linn, 1972) do not share these advantages, because they are not situation-specific in identifying desirable clusters of behaviors.

DEVELOPMENT OF INSTRUMENT

As a framework for the selection of behaviors for the inventory, four areas of functioning were considered: Independent community living, interpersonal behavior, work or training activities, and symptom management. These are roughly based on training areas designated by Liberman, Lillie, Falloon, Hutchinson, and Harpin (1982). The first refers to instrumental activities performed alone to deal with basic living requirements; the second refers to activities performed in relation to other people; the third refers to the realm of study or productivity; and the fourth refers to responsible behavior in dealing with psychiatric and medical symptoms. The inventory is not divided into these four areas by headings, in order to make separate ratings as independent as possible.

Items were first generated by consultations with approximately 25 clinicians in a state psychiatric facility, both inpatient and outpatient. These items were then reviewed by a panel of two psychologists and a social worker at the facility, who also considered items included in the Level of Care and Becker scales, scales currently in use by the New York State Office of Mental Health. Ninety-five items were identified that were scorable by a clinician as present or absent in a patient's current repertoire of behavior, and by a community gatekeeper as required or not for admission. The results of these ratings provide, not quantitative scores, but sets of functional profiles for patients and settings. Additional columns were added for clinicians and gatekeepers to provide further information relevant to training and placement. Parts II and III for gatekeepers focus on historical and other criteria for admission.

METHOD

Subjects. A random selection of 20 psychiatric outpatients were assessed out of a total of 60 patients residing in a private proprietary home for adults and treated at the same outpatient clinic of a state psychiatric facility. The residential setting provides considerable supervision, and is therefore suitable for patients with serious behavioral difficulties. The patients in this sample ranged in age from 45 to 82, with most in their 60's to 70's. Thirteen were diagnosed as schizophrenic, four as major affective disorder, one as dysthymic disorder and one as atypical paranoid disorder.

Procedure. The 20 patients in the sample were rated on the Current Behavior Inventory. The form with instructions and items is attached in the supplement. In each case the patient's primary therapist, a professional clinician responsible for the case, was used as a rater. For the reliability test, a second clinician working in the outpatient clinic and familiar with the patient's functioning rated each patient. There were a total of six raters. Taking the primary therapist ratings alone, a functional profile was produced for each patient indicating the cluster of behaviors out of the total 95 that were currently performed adequately. For behaviors not currently performed, assessments were made of the conditions, if any, that would induce adequate performance. Skill training, compensatory support and additional incentives or opportunities were the three factors considered as possible contributors to future success in performing the listed behaviors.

A setting profile was produced by interviewing the administrators employed by the private residential facility. These people are

responsible for admitting patients, and for transferring them out if they cannot adjust to the setting. The ratings were made jointly by these gatekeepers. The setting profile was the cluster of behaviors, out of the 95, considered necessary for admission and success. The gatekeepers were also requested to indicate which, among the behaviors not regarded as necessary, would make a patient more successful at the setting if they were performed.

RESULTS

Reliability of patient profiles was estimated by counting the number of scoring discrepancies between the two raters, for each of the 20 subjects. This number could range between 0 and 95. The percentage of agreement between raters was calculated by subtracting the number of discrepancies from 95 and dividing this number by 95. The average percentage of agreement for all subjects was 84.7, with a range of 38 and a standard deviation of 10.12.

The validity of the setting profile was estimated by comparing the behaviors rated by the setting gatekeeper as necessary for admission with the current behaviors observed in the sample of patients living in the setting. Out of 95 possible behaviors, the gatekeepers selected 55 that they considered necessary. Each patient's behavior inventory, as rated by his or her primary therapist, was examined to determine the percentage of required behaviors for that setting that were currently being performed. To score 100%, a patient's inventory would have to include all of these 55 behaviors; the other 40 behaviors were not included in this calculation. The average level of behavioral compliance with the setting standards was 84.8%, with a range of 49 and a standard deviation of 13.53.

CONCLUSION

Reliability data for the patient profiles was quite high, indicating that the inventory is likely to be interpreted by different clinicians in a consistent way. Considering the emphasis on objectively defined behaviors, currently observable, it is surprising that reliability was not still higher. Inspection of the scored protocols suggests that more detailed instructions might have been helpful. Some raters did not understand that the first column of the questionnaire referred strictly to current behavior, not to behavior which the patient may be capable of. One rater of the six was associated with a disproportionate number of scoring discrepancies.

The validity of the setting profile was also quite high. Here again, better instructions might have helped. In particular, the items referring to behavior in a workplace seemed to be imperfectly understood by the gatekeepers.

With further refinements there are grounds for the expectation that the Current Behavior Inventory may be useful in making treatment planning for individual patients more precise, and more relevant to the real environment. For a manager in a mental health facility, group data may be used to compare deficiencies in relevant functional areas with existing rehabilitation programs. This would be an improvement over estimating the general level of programming for patients; it would indicate whether the right programs were available.

The methodology can be applied to a wide range of settings, with items added or deleted in accordance with the requirements of each setting. A classification of settings may also be useful. The object is to ensure that clinicians and program planners do not lose

sight of the important interaction between a patient and his or her environment.

SL/HG/PM/jb

January 1986

REFERENCES

Brown, M. (1982). Maintenance and generalization issues in skills training with chronic schizophrenia. In J. Curran and P. Monti (Eds.), Social Skills Training. The Guilford Press, N.Y.

Fairweather, G.W., Sanders, D.H., Maynard, H. Aessler, D.L. (1969) Community life for the mentally ill: An alternative to community care. New York, Aldine.

Goldfried, M.R., & D'Zurilla, T.J. (1969). A behavior-analytic model for assessing competence. In C.D. Spielberg (Eds.), Current topics in clinical and community psychology. Academic Press, N.Y.

Goldsmith, J.B., & McFall, R.M. (1975). Development and evaluation of an interpersonal skill-training program for psychiatric inpatient. Journal of Abnormal Psychology, 85, 51-58.

Growe, G.A., Klass, D., Rudolf, D., Strizich, M. (1977). Community tenure and an assessment of readiness for discharge and community living. Psychological Reports, 4, 1339-1342.

Gruel, L., Linn, M.W., & Linn, B.S., Physical and mental impairment of functional evaluation in the ages: The PAMIE Scale. Journal of Gerontology, 27, 83-90.

Honigfeld, G, Gillis, R.O., Klett, C. (1966). NOSIE - 30: A treatment sensitive ward behaviors scale. Psychological Reports, 19, 180-182.

Liberman, R.P., Nuechterlein, K.H., & Wallace, C.J., (1982). Social skills training and the nature of schizophrenia. In J. Curran and P. Monti (Eds.), Social Skills Training. The Guilford Press, N.Y.

Strauss, G.S., & Carpenter, W.H. Jr. (1974). The prediction of outcome in schizophrenia: II the relationship between predictor and outcome variables. Arch Gen Psychiatry, 31, 39-42.

Wallace, C.J., Nelson, C., Liberman, R.P., Richinson, R. Lukoff, D., Elder, J., & Ferris, C. (1980). A review and critique of social skills training with schizophrenic patients. Schizophrenic Bulletin, 6, 42-46.

APPLICATION OF THE METHOD: AN EXAMPLE OF PROGRAM PLANNING AT HARLEM VALLEY PSYCHIATRIC CENTER

A continuing treatment day center program needs to select and prepare patients for admission to a new vocational program. The challenge for the continuing treatment program is to identify, for groups of patients, the critical target behaviors which would gain them admission to the new setting.

The New Beginnings Continuing Treatment Program has a census of approximatley 80 patients and is located at the Peekskill Mental Health services of Harlem Valley Psychiatric Center. The program provides comprehensive psychiatric services to patients who are expected to require a long course of treatment. Attendance is from three to five hours a day for as many as five days per week.

The Northern vocational center will be located in Northern Westchester, accessible to three Harlem Valley Psychiatric Center Community Clinics with a combined census of 550 patients. A wide range of rehabilitative and supportive programs will be offered that may lead to long term sheltered work, subsidized employment and competitive employment. The center is expected to open with 30 - 40 patients and to serve a census of 100 when fully operable.

STEP I: ESTABLISHING TRIAGE GROUPS

First the Provider Form of the CBI is used to identify the behaviors that are required for admission to the vocational program. The Clinician Form of the CBI is then administered to patients in the Continuing Treatment Day Center. Based on information in the five response columns of the CBI, patients are divided into those who can already perform all of the required behaviors (Triage Group 1), those who cannot do so now but are expected to do so after training (Triage Group 2), and those who are never expected to meet the required standards (Triage Group 3). Table I gives the consecutive numbers for patients who fall into the three groups, as well as the decision rules employed to make the selection.

TABLE I

TRIAGE GROUPS

Group I	Group II	Group III
Consider for Admission now. Only columns 1,3 or 4 on all items	Need skills training. Column 2 on any item and the absence of Column 5	Not eligible. Column 5 on any item
PATIENT #	PATIENT #	PATIENT #
36881	39489	36307	34861	17457
38878	50542	44532	35395	50554
44177	39443	39228	51536	32647
51463	12000	47958	48669	16987
49982	40768	51435	51436	51109
	35402	17984	49307	48028
	46728	24228	09945	31771
		49801		22321
				37338
				51296

STEP II: PLANNING FOR TRIAGE GROUPS 1 AND 3

Patients in Triage Group 1 do not require further training for admission to the Vocational Center. Individual evaluations will be required to determine whether the new program can provide the supports and incentives judged necessary for each patient. The items for which supports or incentives are necessary for patients in Triage Group 1 are listed in Table II.

TABLE II

GROUP 1 NEEDS FOR SUPPORT AND INCENTIVES

ITEM #	PATIENT #
18, 59, 69, 71, 72, 84.	36881
18, 59, 60, 61, 62, 63, 69.	38878
18, 59, 60, 61, 62, 69, 83, 84, 88.	44177
18, 62, 69, 72, 59, 60, 61, 62, 63, 67, 69, 71, 72.	51463

Patients in this group will also require an evaluation of their history and personal characteristics (parts II and III of the CBI) to meet admission criteria of the new program.

Patients in Triage Group 3 are not good candidates for the Vocational Center and should be considered for an alternative treatment plan.

STEP III: PLANNING FOR TRIAGE GROUP 2

Patients in this group are capable of meeting the criteria of the Vocational Center with additional training. The items required for admission (N=20) are listed in Table III.

Factor analysis of these 20 items, based on the entire facility sample (N=613), produced four factors. These factors were used to define four skills training groups, whose target behaviors were the items loading highest on each factor. To be assigned to one of these training groups, a patient must be deficient in at least one of the items listed under a factor. Table IV shows the patient membership and target behaviors for each of the four groups. Titles have been given to the groups to suggest their major themes.

TABLE III

BEHAVIOR REQUIRED FOR ADMISSION

ITEM #	BEHAVIOR
12	Does not touch other people inappropriately
18	Follows verbal instructions accurately
48	Recognizes and avoids common dangers
49	Seeks assistance to deal with common dangers
59	Participates in work
60	Arrives on time for work
61	Work attendance is regular and reliable
62	Works for a sustained period of time
63	Completes assigned tasks
66	Follows directions from supervisor i.e., person in authority
67	Observes safety rules at work/training
69	Copes effectively with work related stress
70	Does not steal from work place
71	Does not usually annoy or interfere with other workers
72	Does not usually argue or fight with other workers
83	Does not engage in self - injurious behavior
84	Does not engage in assaultive behavior
88	Does not exhibit sexually inappropriate behavior
91	Does not abuse alcohol
92	Does not abuse drugs

TABLE IV

TRIAGE GROUP II: CONTENT AND MEMBERSHIP OF THE FOUR TRAINING GROUPS

TRAINING GROUP 1	TRAINING GROUP 2	TRAINING GROUP 3	TRAINING GROUP 4
Focus: Workplace skills	Focus: Alertness	Focus: Personal Intrusiveness	Focus: Harming Oneself
Members: 39489, 39443, 40768, 46728, 36307, 44532, 47958, 51435	Members: 50542, 39443, 12000, 40768, 35402, 36307, 39228, 51435, 17984, 24228	Members: 50542, 51435	Members: 39489, 49801
Item # and Behavior: 59. Participates in work.	Item # and Behavior: 18. Does not touch other people inappropriately.	Item # and Behavior: 12. Does not touch other people inappropriately.	Item # and Behavior 83. Does not engage in self-injurious behavior.
60. Arrives on time for work.	48. Recognizes and avoids common dangers.	84. Does not engage in assaultive behavior.	91. Does not abuse alcohol.
61. Work attendance is regular and reliable.	49. Seeks assistance to deal with common dangers.	88. Does not exhibit sexually inappropriate behaviors.	92. Does not abuse drugs.
62. Works for a sustained period of time.			
63. Completes assigned tasks.			
66. Follows directions from supervisor.			
67. Observes safety rules at work/ training.			
69. Copes effectively with work related stress.			
70. Does not steal from work place.			
71. Does not usually annoy or interfere with other workers.			
72. Does not usually argue or fight with other workers.			

HG/jb
(9/30/86)

BEST COPY AVAILABLE